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Editorial Comment

For The New Year

The members of the American College of Chest Physicians and the Editorial Board of its official publication, *Diseases of the Chest*, start this New Year with thanks and appreciation. We are thankful that we are living in a country where the democratic processes of government are still alive. We are appreciative of everything democracy means to us, and if necessary, we are ready to defend this democratic form of government with our lives.

When we examine the work of the dictators, their ruthless methods, and the suffering inflicted upon innocent people; is there one among us, who would hesitate to make the supreme sacrifice to keep that type of government and philosophy from our shores!

Although we are thankful and appreciative that we are living in America; we realize that the year now enfolding itself, is not going to be an easy one for us. Each of us are going to be called upon to redouble our efforts and our obligations. We must undertake these increased responsibilities cheerfully and wil-

lingly. Each of us has a stake in the survival of our democratic way of life. Petty differences must be cast aside for the welfare of the whole. Imbued with an ideal that we will not tolerate any dictatorial form of government, we will stand united and unswerved behind the ideals we believe in. That is our New Year Resolution!

The American College of Chest Physicians through its Committee on Military Affairs was one of the first medical societies to offer its services to the Government. Many of our Fellows are already in the services of their country and others will soon follow. The Fellows and Associates of the American College of Chest Physicians extend their best wishes for the New Year to those members now in the service. We are certain that their past training and present efficiency will bring credit to them and to their country.

And now, to our associate editors, contributors, advertisers, and subscribers; our very best wishes for the New Year.

C. M. H.

President's New Year Message

The old custom of making New Year resolutions was one which could well fall into its present disrepute, yet like many another custom made stale by repetition, it has its points. There is wisdom in pausing now and then to take stock of ourselves. If, in the analysis, individually or collectively, we find that we have lagged, it is well to change methods or to speed up the present ones. And if we find that we *have* kept faith and achieved and maintained a certain standard, we should not spend too much time patting our backs, but should set up a still higher goal, even though we may meet with opposition and disappointment. However, I am not anticipating anything but success from our concerted efforts to further promote the purposes and objectives of the American College of Chest Physicians. I merely wish to stress the desirability of not stopping in our course. The only excuse for looking backward is to measure what has been done against what remains to be done. Once a goal is reached, its importance dwindles in relation to what lies beyond. Perhaps the substance of what I am trying to say has been epitomized in the admonition "Be not weary in well-doing."

At best, I can mention but briefly some developments since our June meeting. In this short time there has been a fine extension of formation of county and state tuberculosis committees. Such organizations cannot help but increase an interest in earlier recognition of tuberculosis and add to the knowledge of the general practitioner regarding its care and treatment.

We are making tremendous strides in the new membership campaign and I am happy to report a substantial gain in the number of Fellows and Associates. This increase is due to a real interest, though no doubt the prospect of higher fees after the first of this year did speed action on the part of those who were afflicted with the virus of procrastination.

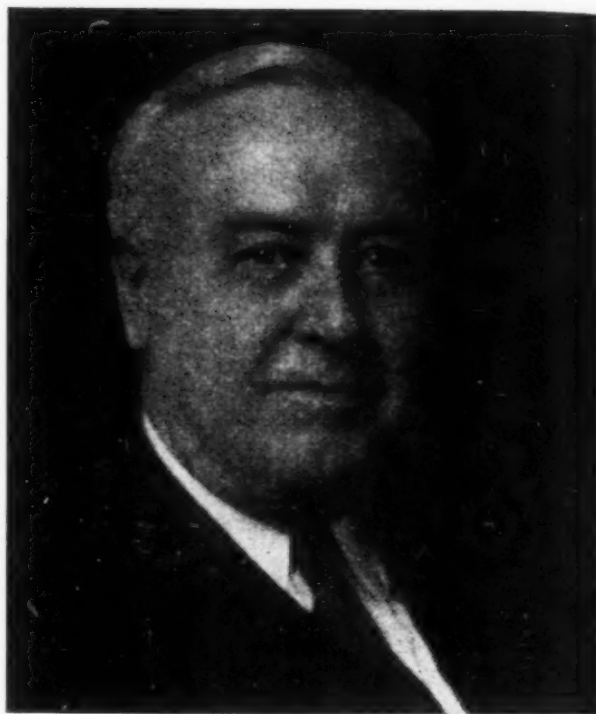
Our relations with the American Trudeau Society are entirely harmonious, which is pleasing to us all, since the control of tuberculosis requires the best efforts and the willing cooperation of every person and every organization.

Removal of the business office to 500 North Dearborn Street, Chicago, already proves to have been a wise decision because of the greater convenience this location affords to the officers and fellows.

A meeting of the Board of Regents is planned to be called for early February in Chicago to transact business which would otherwise take up valuable time at our annual sessions.

Plans are well under way for the general meeting in Cleveland next June. A series of interesting and informative presentations and discussions is being planned, including a repetition of "Information, Please," which proved so popular at the New York Meeting.

Undoubtedly much tuberculosis will be uncovered in the examination of draftees, which will demand our serious consideration. These young men will be of preferential age and should have immediate care and treatment. This, and the uncertainty of the future, in general, indicates greater need for sanatorium beds, and more physicians trained in the care of the tuberculous.



In a former address I stressed the importance of undergraduate instruction in tuberculosis. I am not forgetting that there must be intensive teaching in general medicine, surgery and other specialties, but I must continue to maintain that tuberculosis, because of its insidious onset, the wide-spread incidence of the disease and ignorance concerning it, should be recognized earlier.

I wish, also, to add that although early diagnosis is of prime importance, there still remains the task of educating the patient. This is one reason why I am anxious that a standard be set to which all sanatoria for tuberculosis should conform, if they are to be placed on an accredited list, not for the purpose of giving the sanatorium an empty honor, but because the better equipped and administered a sanatorium is, the more quickly will recoveries be achieved, and the more wide-spread will be the confidence engendered by the teachings and practices of the institution. A belief that spreads from one person to another can be a power for good as well as a power for evil, and if each patient who leaves an institution goes out armed with confidence in the methods used and taught in the sanatorium, this confidence will spread like ripples caused when a stone is thrown into the water.

What I have said in the preceding paragraph applies more or less urgently to the objectives for which all committees have been appointed. All have their definite functions as factors in the production of better trained physicians, and better trained patients with resultant knowledge of how to detect tuberculosis, how to recover, and how to prevent it. Let us, then, as accepted Fellows of the American College of Chest Physicians, RESOLVE this NEW YEAR to go onward and upward toward the eradication of tuberculosis and to make the American College of Chest Physicians synonymous with hope and progress.

JOHN H. PECK, M.D., F.A.C.P., F.A.C.C.P.
President,
American College of Chest Physicians.

Diagnosis and Treatment of Tuberculosis

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San Antonio, Texas

Tuberculosis is still one of the major health problems affecting all peoples of the civilized world. It remains the leading cause of death in our most useful and productive age groups. It is a disease which, in mild or severe form, affects at least half of the human race. Tuberculosis is responsible for fully one-seventh of all deaths, and kills about one-third of those who perish between the ages of 15 and 45. It is so ruthless that it causes twice as many deaths as automobile accidents, commonly thought to be the greatest "killer."

Tuberculosis is most insidious in its onset and often relentless in its course. However, it is a disease which may be largely prevented if we merely cease our indifference, our inactivity, and our unholy procrastination. It is true that some few have worked so diligently as to reduce the mortality rate from 200 annual deaths per 100,000 population in 1900, to the present rate of less than 60 deaths per 100,000 population, an average applicable to the general whole age group. Encouraging as this may seem, we have not yet reached our goal of bringing the disease under control, for the morbidity and mortality rates are still first in the economic and productive age groups.

To enumerate all the weapons which must be employed in the control of this disease is beyond the scope of this paper, our desire is rather to bring to attention the pertinent facts concerning control and eradication. The foremost factor of this problem appears to be the simple matter of diagnosis—*early diagnosis*—followed by prompt and adequate treatment. Proof of this statement is attested by the fact that ninety per cent of the early cases recover and return to their former economic status when diagnosis and treatment are not delayed.

To overcome tuberculosis we must find the patient in a curable stage. The question of early diagnosis and treatment is often made complex by both the patient and the attend-

ing physician, because the patient is first seen by the general practitioner or family physician. As a result it is usually weeks and oftentimes months before the patient reaches the sanatorium or takes adequate treatment elsewhere. Thus, the problem of eradicating tuberculosis in a community comes to be the concern of general practitioner and family physician. It would, however, be quite unfair to place the full responsibility of this problem on the physician. Far too many patients delay seeking medical advice and care because the early warning symptoms are usually mild in nature and are hardly noticeable. These symptoms may include cough, loss of weight, fatigue, and gastro-intestinal disturbances. But, in the imperfect estimation of the patient, they are negligible and do not demand medical attention. This delay in diagnosis can be fixed, of course, and can be charged to the ignorance and negligence of the patient. For this we can make a certain allowance. After the patient with one or more subjective symptoms visits the physician there is a division of responsibility as far as the end-result is concerned. The physician must make a definite diagnosis and outline a plan of treatment. The patient must accept the diagnosis and adequately follow the plan of treatment. Courage and persistence are essential.

In reviewing four hundred histories of the Woodmen of the World Hospital it was found that 289, or 71.7 per cent of the patients did not think their symptoms serious enough to warrant a visit to the physician. The time factor from the appearance of symptoms to the first visit to the physician varied from three months to two years or more. Certainly, this delay on the part of the uninformed calls for an intensive campaign in educating the public relative to the common symptoms of tuberculosis and the urgent need for early diagnosis.

In a study by Sedar entitled "The Cost of Tuberculosis with Special Reference to Adequacy of Medical Care and Treatment," it

* From the Woodmen of the World Hospital.

was found that 261, or 74.7 per cent of the 361 patients were in the advanced stages, and that the cost of institutional treatment for 300 patients in the first, second, and third stages was \$523, \$873, and \$1,113 respectively.

For three hundred patients there was an aggregate expenditure of \$261,780. If the patients had been admitted to an institution while in the first stage, the cost would have been \$159,690, a saving of \$102,180. Such is the price of delay.

Total wage losses for the first, second, and third stages were \$596, \$979, and \$1,251 respectively, while the combined cost of hospitalization and wage loss was \$1,128, \$1,852, and \$2,369 for first, second, and third stages.

The Texas Tuberculosis Sanatorium in its clinical report of 1936-37, shows 2,253 patients admitted. Of these 3.9 per cent were classified as Minimal; 79.6 per cent were Advanced; 16.5 per cent were Non-Tuberculous and Childhood Tuberculosis.

In the Woodmen of the World Hospital we find that on admission patients were classified as Minimal, 10.6 per cent; Advanced, 76 per cent; Non-tuberculous and other conditions, 13.4 per cent.

The statistics of these two institutions show that the advanced stage predominates, a condition which should not exist, and which could be prevented to a great extent by education of the public and by earlier diagnosis.

We have kept careful records of the 2,798 patients who have come under our observation in the past fifteen years, both during residence and after discharge. In case of death a notice is sent us at San Antonio, from the Home Office at Omaha, giving the cause of death as recorded on the death certificate. This information provides us with genuine knowledge as to whether the patient is living or dead.

The end-results of these 2,798 discharged patients are expressed in terms of "Living" and "Dead," according to the stage of the disease. In the respective stage groups we have living, 91.8 per cent in the first; 70.6 per cent in the second; and 37.9 per cent in the third. These figures confirm the oft repeated statement that "Early Diagnosis means Early Recovery and Lasting Results."

In studying the application diagnoses of 2,550 patients sent to the Woodmen of the

World Hospital we have found a wide discrepancy in the diagnoses made by the physicians who signed the applications and those we made after admitting the patients.

The application diagnoses made by physicians showed 664 early cases; 1,564 moderately advanced; and 322 far-advanced. After making a painstaking study of these cases, by employing physical, x-ray, and laboratory examinations, we found that the 664 "early" cases were to be reclassified as 145 minimal, 250 moderately advanced, and 143 far-advanced. The reported 1,564 moderately advanced were classified by us as 134 minimal, 608 moderately advanced, and 673 far-advanced. Among the 322 far-advanced cases, as shown by application, we found 12 minimal, 72 moderately advanced, and 222 far-advanced. We also found that 8.8 per cent of the applying diagnoses were either non-tuberculous or else the patient was suffering from some other acute or chronic respiratory disease. Thus, one can see that under-diagnosis of tuberculosis is quite a serious matter.

Unfortunately, we find a similar problem among enthusiastic workers who are prone to over-diagnosis. A few years ago Lewison of Chicago wrote:

"Since the beginning of the anti-tuberculosis campaign about twenty-five years ago, two thoughts have dominated the medical profession in the promotion of this crusade. The first was to diagnose tuberculosis as early as possible; the second was to suspect it in every chronic pulmonary disease. Although the results have been very satisfactory by reducing the mortality of this disease over 50 per cent, this period of over-enthusiasm displayed, especially by those actively interested in this disease, has caused many non-tuberculous conditions to be diagnosed as tuberculosis. Another cause of this is that symptoms of many other diseases simulate those of tuberculosis. Practically all tuberculosis sanatoria have cases of non-tuberculous disease."*

Canada's beloved Stewart likewise understood the importance of a balanced diagnosis in pulmonary tuberculosis. In one of his many enlightening articles he wrote:

"In the pages of PUNCH, not long since,

* Lewison, Maurice: *Illinois Medical Journal*, Vol. XLIX, No. 3, pp. 213-215.

two flappers discussing their respective medical advisors decided they were of two types familiar to all of us, and, of which, we know many honoured representatives, one a 'pooh-pooh-er,' the other a 'wind-up-er.' In relation to tuberculosis, the 'pooh-pooh-er,' the man who habitually under diagnoses, who has comfortable words of Peace! Peace! when there is no peace, was a tremendous nuisance twenty years ago and still survives. But the man who habitually over-diagnoses, who 'gets his patients' wind up' without sufficient cause is more numerous than he used to be, and something of a nuisance also.

"The 'pooh-pooh-er' has many alibis. He has known the family all his life and there has been no tuberculosis on either side of the house. 'The girl looks as well as she ever did. Her chest is sound as a bell' (upon a half-minute examination with a defective stethoscope, and through underclothing). Blood? Doubtless from the throat. Pain? A little pleurisy, nothing like tuberculosis. Cough? Merely a cold; everybody has colds; or 'flu' hanging on a bit. Spring will clear it up. Fatigue? Not enough exercise; she should get out more.' He will think and talk of everything possible before and besides tuberculosis. He simply wouldn't take the responsibility of suggesting tuberculosis to this frail little woman; the shock would be enough to kill her. Bacilli? Laboratory men make many mistakes. Anyway even if it is tuberculosis, nearly everybody has it. Why worry?

"The 'wind-up-er,' who is inclined to over-diagnose tuberculosis, is nervous and apprehensive. He heard a rale, or thought he did, somewhere in the chest; or dullness has been defined, or at least suspected; or, there was a speck of blood a little larger than a pin-head; or there has been a cough for a week. Plates show some dirtiness somewhere. There has been a positive Von Pirquet reaction. A few pounds of weight have been lost. The reason must be tuberculosis and the prognosis must be grave.*

Thus, it has been shown that our problem not only involves making the diagnosis early, but also making it accurately. There are non-tuberculous diseases of the chest that simulate pulmonary tuberculosis and have to be

differentiated. Between under-diagnosis and over-diagnosis there is a happy medium of right-diagnosis, and if searched for earnestly and sincerely, it will be found.

Diagnosis of Pulmonary Tuberculosis

Prompt discovery of tuberculosis is the alpha and omega of attack toward a cure. Early diagnosis does not depend on any one method. In one case a physical examination may be used for the diagnosis. In another case it may be the history, x-ray, or laboratory examination. To establish the diagnosis of tuberculosis, or any other chest disease, a combination of the following factors is necessary:

1. Careful history.
2. X-ray examination.
3. Complete physical examination.
4. Laboratory examination, consisting of sputum, sedimentation rate, and diagnostic tuberculin.
5. Time.

History

As Pottenger has said, "The clinical history . . . is the foundation on which the diagnostic edifice is to be built." A careful history leads to diagnosis and determination of active disease. Stress is laid on a well developed and well recorded history for the obvious reason that symptoms of pulmonary tuberculosis in the early stages do not vary much from normal, and receive little consideration from the patient. After listening to the patient's complaint, and concluding that it points to lung disease, the physician must then develop the history of symptoms peculiar to tuberculosis.

There are seven common symptoms associated with advancing tuberculosis, and their presence warrants investigation as enumerated. They are:

- 1—Unreasonable fatigue: A person completely exhausted after ordinary work or play may be suffering with tuberculosis.
- 2—Cough: An habitual husky throat, a cough which persists for weeks, a "chest cold" or a cold which simply will not clear up—all are common warning symptoms.
- 3—Indigestion: Persons with failing appetites and those who lose interest in food after a few mouthfuls, or who suffer what

* Stewart, David A.: *The Canadian Medical Association Journal*, 1928, Vol. XVIII, pp. 375-378.

is commonly called "indigestion," certainly should take heed of their symptoms and look to their lungs.

4—Loss of weight: A consistent loss of weight without known cause may be a sign of approaching tuberculosis.

5—Pain in the chest: Especially a dull pain between the shoulder blades needs the attention of a physician.

6—Irritability, (often a complaint, and diagnosed as "neurasthenia" or "nervous breakdown"), should arouse suspicions of tuberculosis.

7—Hemoptysis or Pleurisy: These should be considered due to pulmonary tuberculosis until proven otherwise.

The appearance of one or more of these symptoms should lead the physician to look for tuberculosis.

X-ray Examination

X-ray examination is next in importance to the history, and the examiner should make it a rule to take at least one film of the chest before advising the patient that he does or does not have pulmonary tuberculosis.

Physical Examination

Physical examination is necessary in the diagnosis of tuberculosis, and the physician should never hurry. Inspection, palpation, percussion, and auscultation should be carried out step by step and in the order mentioned.

Physical examination cannot be learned by reading a book or by listening to a paper. Actual practice is necessary before one acquires the requisite skill for examining, and physical examinations are important enough to justify any effort put forth in acquiring such skill.

Laboratory Examination

The value of persistent search of the sputum for tubercle bacilli cannot be over emphasized. It is our practice to make nine sputum examinations including concentrations upon each patient at admission before a negative report is given. These cases also

have additional sputum examinations at periodic intervals during their stay at the hospital. An elevated sedimentation rate is indicative of an infectious process and should prompt one to search for pulmonary tuberculosis.

The tuberculin skin test is of the utmost importance in diagnosing adult tuberculosis in patients with negative physical, x-ray, and laboratory examinations. Often it will produce an exudative reaction in the lung, thereby definitely establishing the diagnosis at an early stage.

Time

The element of time must be stressed, for the physical signs in early tuberculosis are evanescent, and repeated examinations may be required to establish the diagnosis. A most important feature in the suspected tuberculosis patient is keeping him under close observation to pick up the first definite sign to make its appearance.

Differential Diagnosis

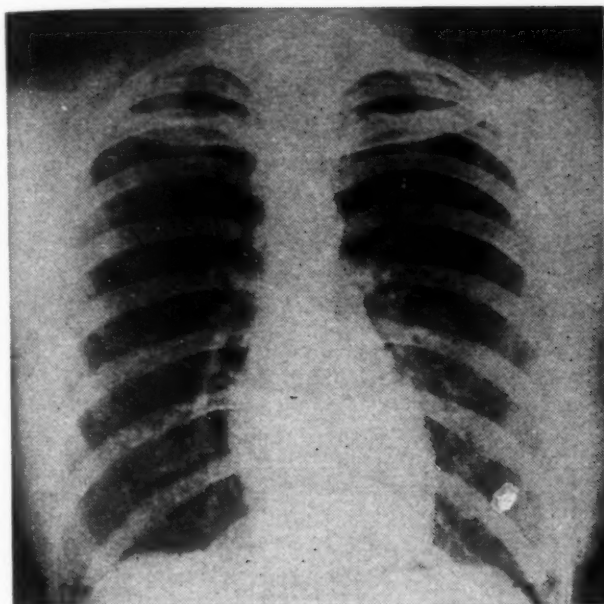
There are many common diseases, both pulmonary and non-pulmonary, that simulate tuberculosis and must be differentiated from it. Lack of space forbids a discussion of these several conditions, but those most often encountered are:

1. Primary carcinoma.
2. Hyperthyroidism.
3. Subacute infective endocarditis.
4. Pulmonary abscess.
5. Fungus diseases.
6. Bronchiectasis.
7. Silicosis.

Case Histories with X-rays

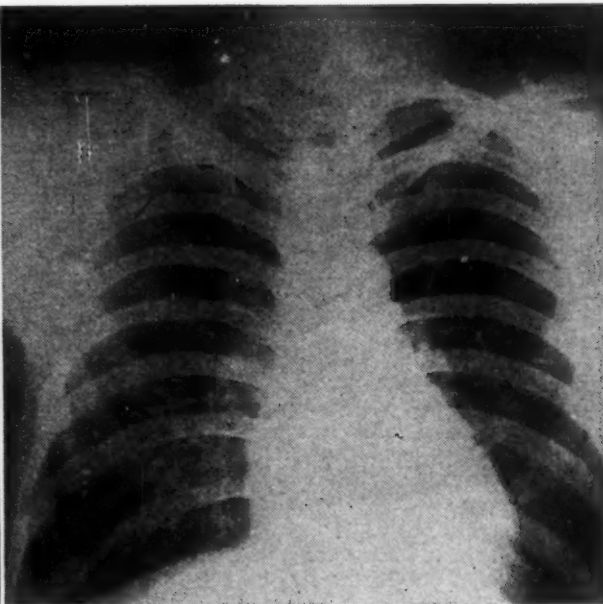
The following cases, with which we have had experience in the Woodmen of the World Hospital, will demonstrate the importance of the various factors in diagnosis and treatment of early tuberculosis. The x-rays emphasize the importance of early diagnosis, while the clinical photographs illustrate the value of early and adequate treatment.

DIAGNOSIS



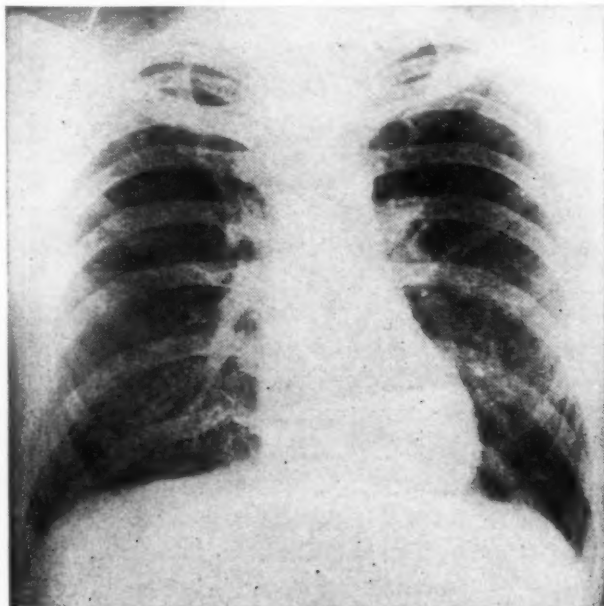
Case 1, Fig. 1, V. R.
EARLY TUBERCULOSIS

Case 1, Fig. 1, V. R., aged 22, female. Good health to September, 1935, when she became highly nervous and irritable. Cried on slight provocation. In October, 1935, she developed pain in the right chest. This was followed by slight cough and expectoration. Physical and sputum examinations were negative for tuberculosis. X-ray shows definite tuberculous infiltration in the right second interspace. The diagnosis was made on history and x-ray.



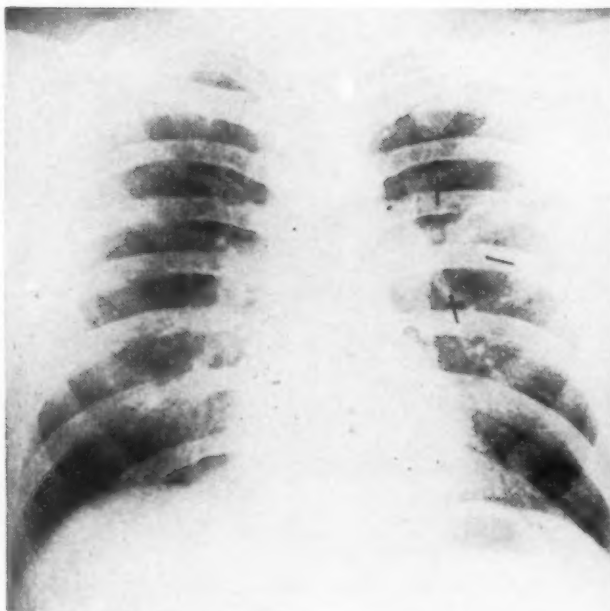
Case 2, Fig. 2, P. P.
EARLY TUBERCULOSIS

Case 2, Fig. 2, P. P., aged 34, male. On examination for employment the diagnosis was made by x-ray in April, 1938. History of malaise, cough, loss of weight, and night sweats in October, 1937. On admission to the Hospital in June, 1938, there were no symptoms of pulmonary tuberculosis. Physical and sputum examinations were negative. X-ray revealed infiltration in the first interspace of the right lung. Our diagnosis was made on history and x-ray.



Case 3, Fig. 3, B. S.
EARLY TUBERCULOSIS (Negative X-ray)

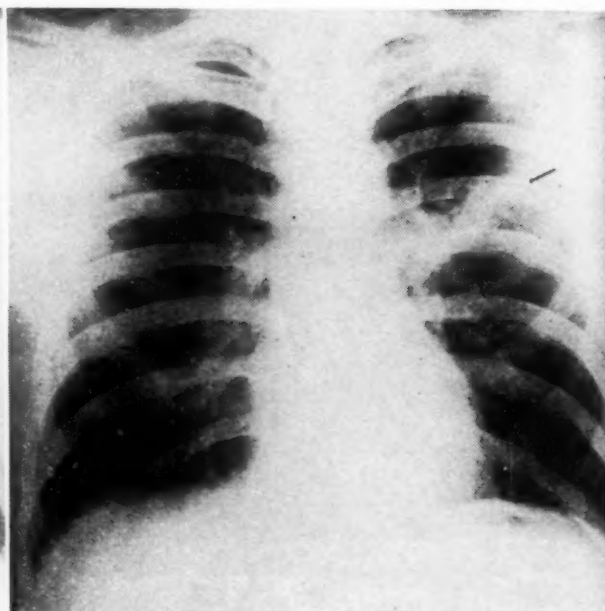
Case 3, Fig. 3, B. S., aged 30, male. Good health to November, 1937, when he had a pulmonary hemorrhage, followed by productive cough, loss of weight and strength. On admission to the Hospital he had the common symptoms of pulmonary tuberculosis. Physical and x-ray examinations were negative, but the sputum was positive for tubercle bacilli.



Case 4, Fig. 4-a, H. McD.

SUSPECTED TUBERCULOSIS

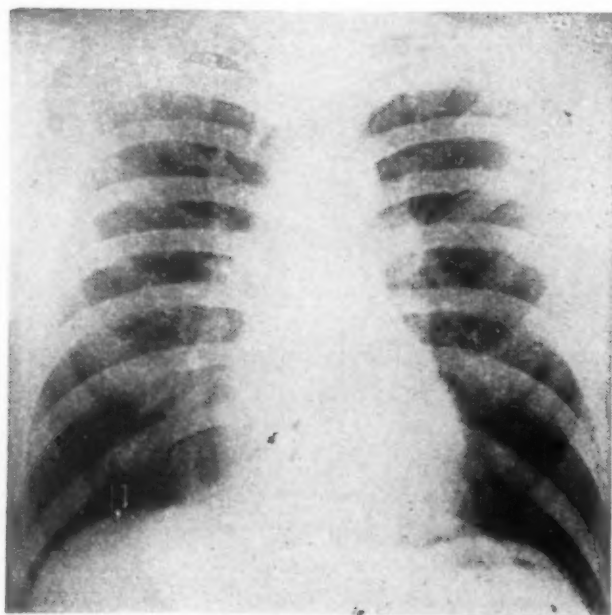
Case 4, Figs. 4-a, 4-b, 4-c, H. McD., aged 24, male. Was in good health to November, 1937, when he developed pain in the left chest, followed by productive cough, malaise, and loss of weight. When admitted to the Hospital the physical and sputum examinations were negative, but x-ray revealed a suspicious lesion adjacent to the left hilum (Fig. 4-a).



Case 4, Fig. 4-b, H. McD.

EXUDATIVE REACTION AFTER TUBERCULOSIS

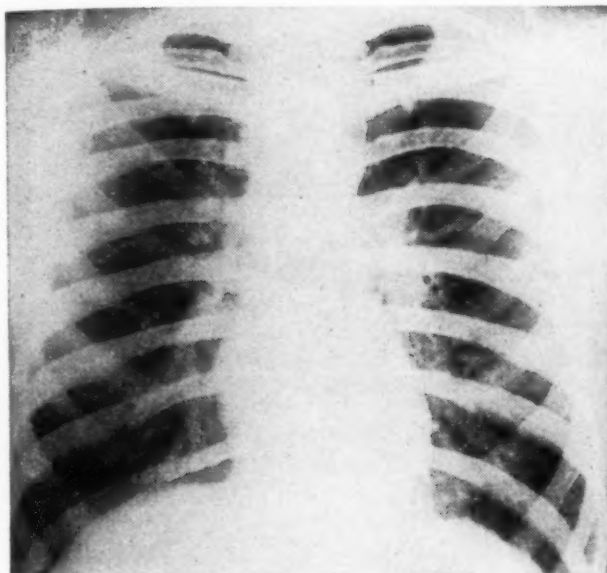
An intracutaneous test of tuberculin (P. P. D. .005 mg.) was given. This was followed by physical and x-ray examinations. The x-ray (Fig. 4-b) shows an exudative lesion extending from the left hilum into the second interspace.



Case 4, Fig. 4-c, H. McD.

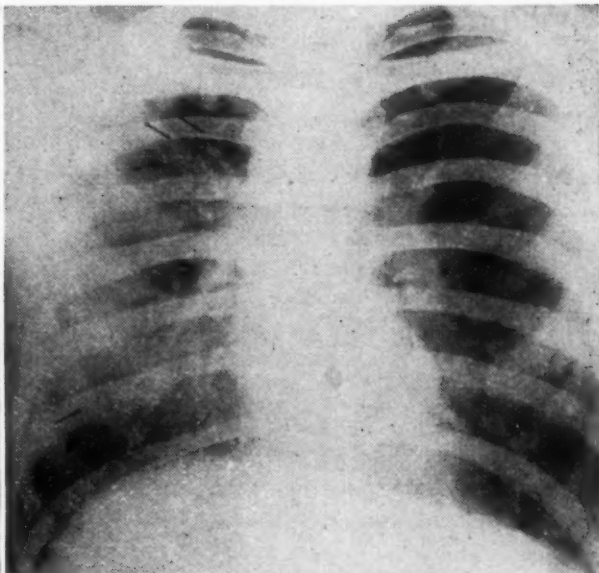
HEALING OF EXUDATIVE LESION

Six months after admission to the Hospital the x-ray (Fig. 4-c) shows healing and resolution. The diagnosis in this case was made on tuberculin, x-ray, physical examination, and history.



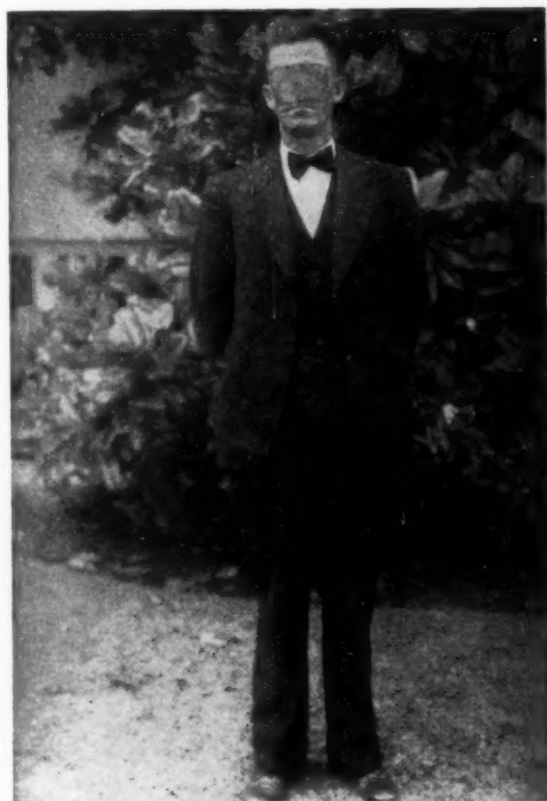
Case 5, Fig. 5-a, F. C.
SUSPECTED TUBERCULOSIS

Case 5, Figs. 5-a, 5-b, F. C., aged 33, male. Productive cough, pain in chest, loss of weight and strength, following an attack of influenza in October, 1937. On admission to the Hospital he had all of the common symptoms of pulmonary tuberculosis. The sputum examination was negative, but fine crackling rales were heard over all of the right lung. The film (Fig. 5-a) showed suggestive infiltration in the hilum and first interspace. Diagnostic tuberculin (P. P. D. .005 mg.) was given. This was followed by local, focal, and constitutional reactions. The second film (Fig. 5-b) showed an exudative lesion in the apex, first and second interspaces, on the right side. The diagnosis of tuberculosis was made on history, physical examination, and tuberculin reaction.



Case 5, Fig. 5-b, F. C.
EXUDATIVE TUBERCULOSIS—Right Apex.

RESULTS OF SANATORIUM TREATMENT



Case 6, Fig. 6-a, O. N. S.
PHOTOGRAPH ON ADMISSION TO HOSPITAL



Case 6, Fig. 6-b, O. N. S.
PHOTOGRAPH ON DISCHARGE FROM HOSPITAL

Case 6, Figs. 6-a, 6-b, O. N. S., aged 38, male. Entered the Woodmen of the World Hospital May 26, 1939. The chief complaint was productive cough, hemorrhage, and loss of strength. He weighed 150 pounds. Fine crackling rales were heard over the apex of the left lung, and a diagnosis of incipient pulmonary tuberculosis was made. This patient spent twenty months in the Hospital and was discharged arrested. Weight on discharge was 198 pounds. The photographs were made on admission and discharge.



Case 7, Fig. 7-a, T. U.

PHOTOGRAPH ON ADMISSION TO HOSPITAL

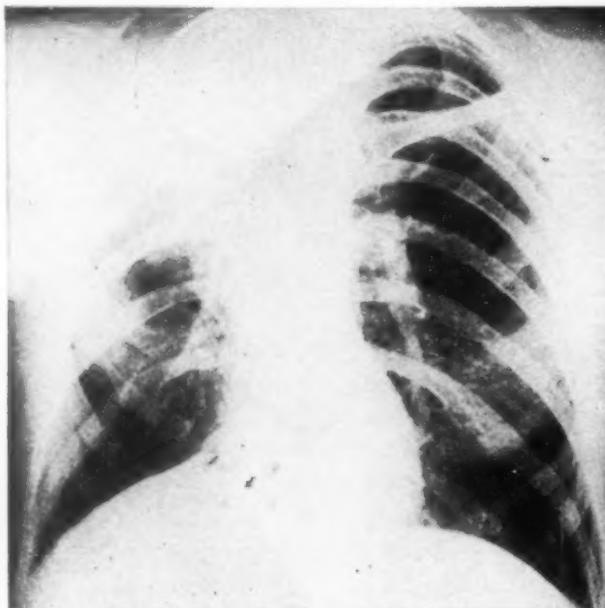
Case 7, Figs. 7-a, 7-b, T. U., aged 57, male. On entering the Hospital September 9, 1936, this patient weighed 138 pounds (Fig. 7-a). He complained of productive cough, malaise, loss of appetite and weight. There was an early lesion in the upper lobe of the right lung. After nearly ten months' treatment he was discharged as apparently arrested, and weighed 185 pounds (Fig. 7-b).



Case 7, Fig. 7-b, T. U.

PHOTOGRAPH ON DISCHARGE FROM HOSPITAL**RESULT OF ACTIVE TREATMENT**

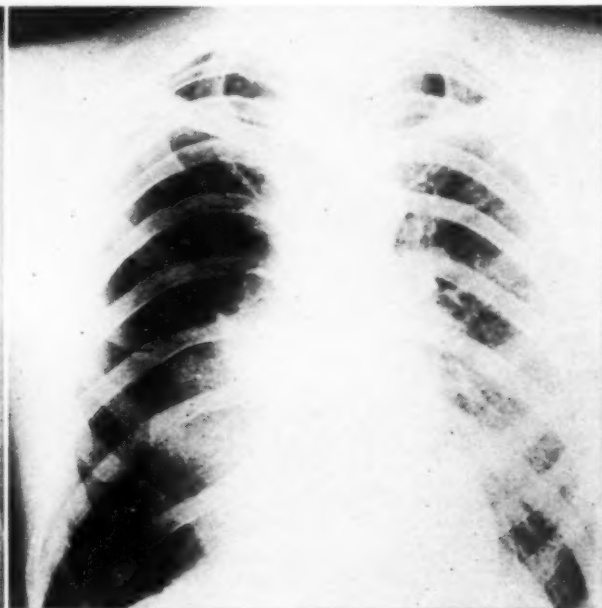
Active treatment implies the use of surgery. The thoracic surgeon of today is a great ally of the chest specialist. During the past decade thoracic surgery has come to the fore-front in the treatment of advanced open cases. Many cases that were formerly considered hopeless are now being restored to health and economic independence by surgery. Passive treatment, or bedrest, is effective in 90 per cent of the early cases, but is insufficient in the advanced stages. The following case illustrates the value of active treatment.



Case 8, Fig. 8-a, A. P. P.

UNRESOLVED TUBERCULOSIS PNEUMONIA—Right

Case 8, Figs. 8-a, 8-b, A. P. P., aged 47, male. Had pneumonia in January, 1938, and failed to recover. On admission to the Hospital March 12, 1938, his chief complaint was productive cough, fever, malaise, loss of appetite and weight. Fine rales were heard over the upper two lobes of the right lung; the sputum contained tubercle bacilli. Pneumothorax was instituted immediately. The second film (Fig. 8-b) shows an excellent collapse, and there has been a gain of 23 pounds.

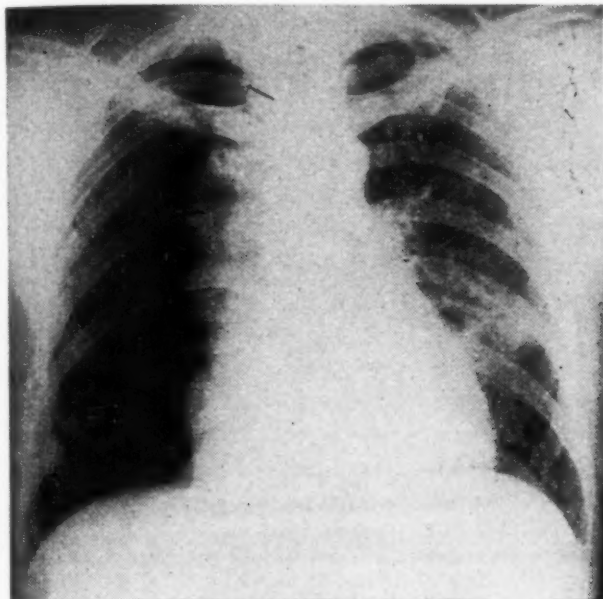


Case 8, Fig. 8-b, A. P. P.

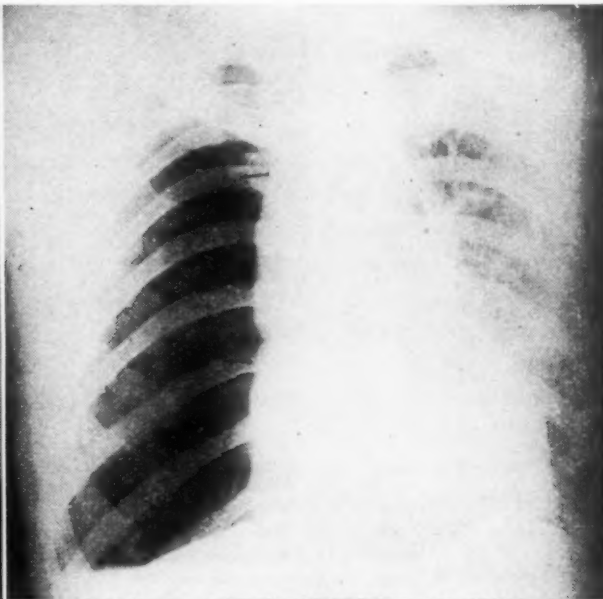
PNEUMOTHORAX—GOOD COLLAPSE

INTRAPLEURAL PNEUMONOLYSIS

Artificial pneumothorax is frequently unsuccessful because cavities are held open by adhesions. In selected cases, intrapleural pneumonolysis may be employed to sever the adhesions, with a resultant closure of the cavities.

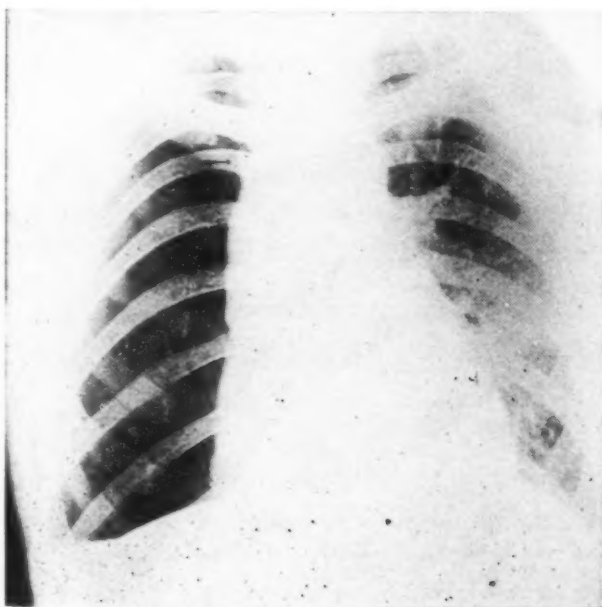


Case 9, Fig. 9-a, T. J. V.
ADHESIONS AT RIGHT APEX
Cavity Open



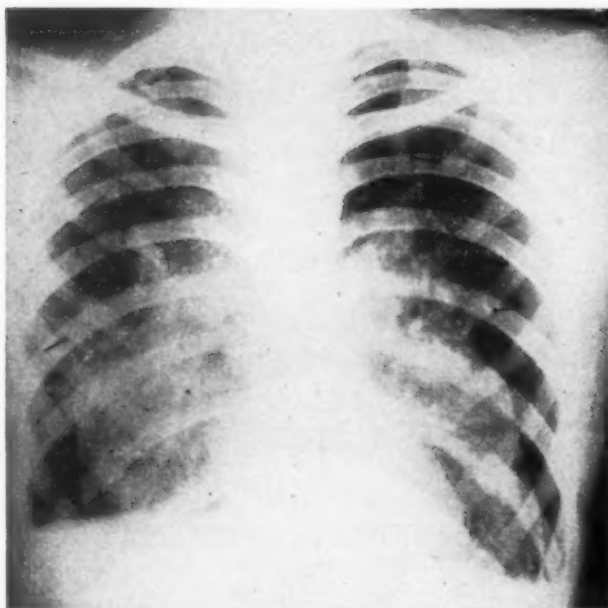
Case 9, Fig. 9-b, T. J. V.
CAVITY NOT COMPLETELY CLOSED
Sputum Positive

Case 9, Figs. 9-a, 9-b, 9-c, T. J. V., aged 23, male. Entered the Woodmen of the World Hospital September, 15, 1937. There was a total tuberculous involvement of the right lung. Artificial pneumothorax was instituted December 23, 1937. Due to adhesions the cavity remained open and the sputum remained positive (Fig. 9-a). Intrapleural pneumonolysis was done June 11, 1938. The second film (Fig. 9-b) was made shortly afterward, at which time the sputum was still positive.

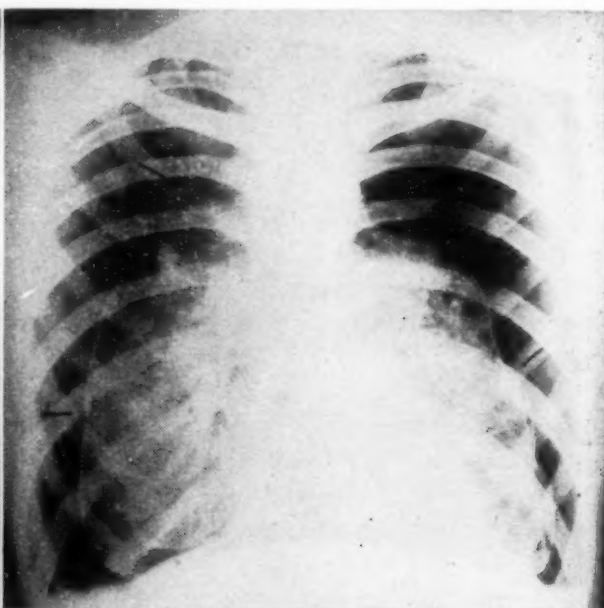


Case 9, Fig. 9-c, T. J. V.
CAVITY COMPLETELY CLOSED
Sputum Negative

When the third film (Fig. 9-c) was made, the cavity had closed and the sputum was negative. When the patient was discharged all symptoms had disappeared and the physical condition was excellent.



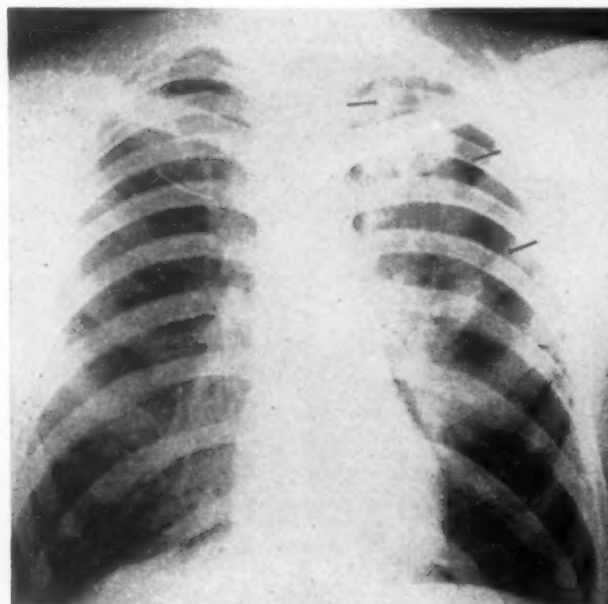
Case 10, Fig. 10-a, T. O.
ADHESIONS AT LEFT APEX.
Cavity Open—Sputum Positive



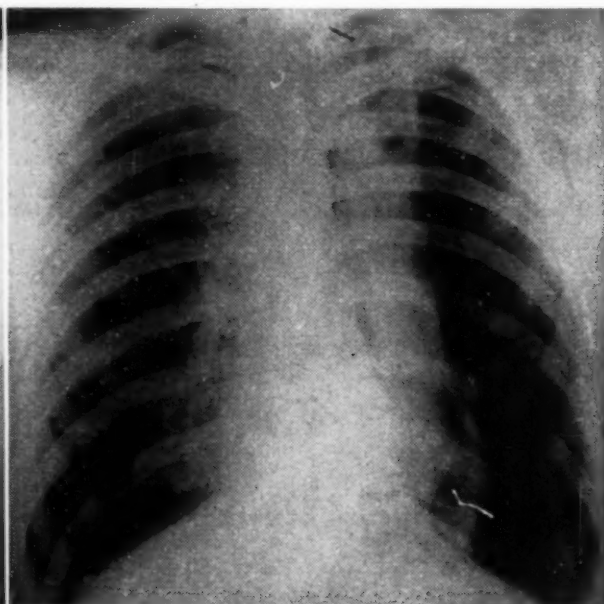
Case 10, Fig. 10-b, T. O.
ADHESIONS SEVERED AT LEFT APEX.
Cavity Closed—Sputum Negative

Case 10, Figs. 10-a, 10-b, T. O., aged 18, male. First consulted a physician in June, 1936, for productive cough and loss of appetite. A diagnosis of tuberculosis was made then, but he continued to work until March, 1939. On admission to the Hospital his symptoms were severe. Rales were heard over both lung fields, the sputum was highly positive, and the sedimentation rate was far above normal. Within a month of admission pneumothorax was instituted bilaterally. Due to adhesions a cavity in the left apex was held open (Fig. 10-a). The adhesions at the left apex were released by intrapleural pneumonolysis (Fig. 10-b), and the sputum has now been negative for several months.

THORACOPLASTY



Case 11, Fig. 11-a, B. H. M.
Condition on Admission—Cavity Open
PARTIAL COLLAPSE OF LEFT UPPER LOBE

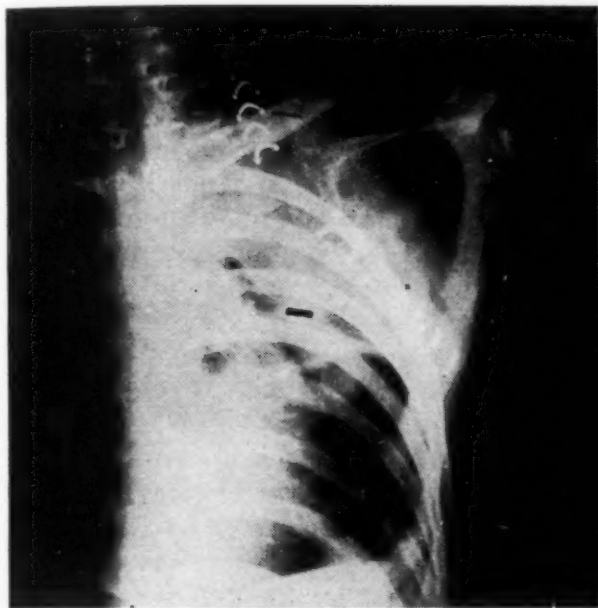


Case 11, Fig. 11-b, B. H. M.
DENSE ADHESIONS AT LEFT APEX.
Cavity Open

Case 11, Figs. 11-a, 11-b, B. H. M., aged 37, male. Began to cough and lose weight in March, 1937. Consulted a physician for the first time in August, 1937, because of "cold in the chest." Without physical or x-ray examination a diagnosis of influenza was made. After a week in bed he felt better and returned to work. In January, 1938, there was a recurrence of the "chest cold," accompanied by pain in the left chest. The patient was sent to a teaching hospital for diagnosis and treatment. While there the sputum was examined and was negative for tubercle bacilli. A final diagnosis of "unresolved pneumonia, left upper lobe," was made before discharge on February 7, 1938.

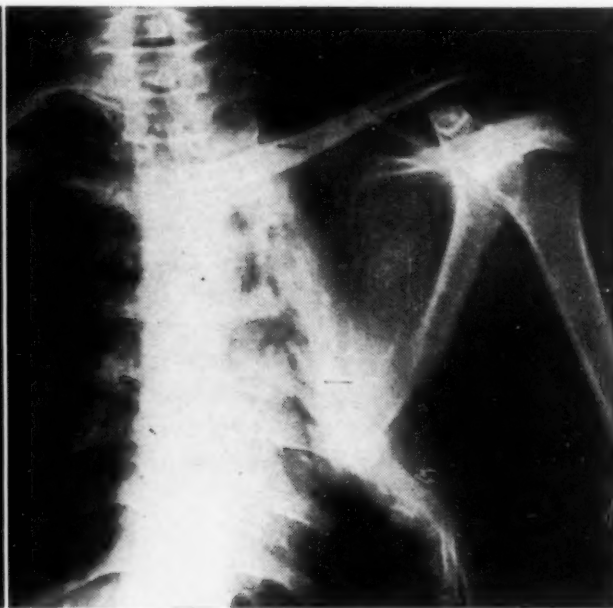
After leaving the hospital a chest specialist was consulted, and a diagnosis of tuberculosis was made after physical, x-ray, and sputum examinations. Artificial pneumothorax was instituted immediately, and the patient entered the Woodmen of the World Hospital March 24, 1938 (Fig. 11-a). Pneumothorax was continued until it was apparent that adhesions were preventing closure of an apical cavity (Fig. 11-b).

THORACOPLASTY



Case 11, Fig. 11-c, B. H. M.

FIRST STAGE THORACOPLASTY—Left



Case 11, Fig. 11-d, B. H. M.

SECOND STAGE THORACOPLASTY—Left

Case 11, Figs. 11-c, 11-d, B. H. M., aged 37, male. Intrapleural pneumonolysis was attempted June 11, 1938, but was unsuccessful because of the density of the adhesions and their close proximity to the subclavian artery. Thoracoplasty was then decided upon, and this was done in two stages (Figs. 11-c, 11-d). The patient was discharged in good condition, and, for the past nine months has worked at his former occupation.

This case emphasizes the importance of early diagnosis and illustrates the value of thoracic surgery in advanced cases that were formerly considered hopeless.

Conclusions

1—Patient and physician must share alike the responsibility for delayed diagnosis, and for the large number of advanced cases.

2—Tuberculosis can be unmasked by modern methods.

3—Early discovery of tuberculosis, with efficient and adequate care, means 90 per cent recovery on passive treatment.

4—The percentage of advanced cases is still too high.

5—Tuberculosis ranks first as cause of death between the ages of 15 and 45.

6—Right diagnosis of chest disease is better than over or under diagnosis.

7—Thoracic surgery has no place in early tuberculosis, but is of prime importance in advanced cases.

TUBERCULOSIS ASSOCIATIONS HELP
DISTRIBUTE JOURNALS

Twenty-five Tuberculosis Associations in Ohio and West Virginia placed orders for 727 copies of the OHIO and WEST VIRGINIA STATES ISSUE of *Diseases of the Chest*, which was published as a special issue in December, 1940.

These copies have been distributed, with the compliments of the associations to physicians in Ohio and West Virginia. Complimentary remarks, which have already been received from physicians getting these copies,

is ample proof that the journal is a welcome visitor in the offices of physicians who do not specialize in chest diseases, but, who are nevertheless interested in learning more about chest conditions.

The Editorial Board of *Diseases of the Chest*, takes this opportunity to express its appreciation to these Tuberculosis Associations in Ohio and West Virginia for their support of the Journal, and is ever ready to cooperate with recognized organizations in the furtherance of education in the fight against tuberculosis.

The Tuberculosis Problem in the Mobilization of Military and Naval Personnel*

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This problem consists very simply of rejecting for military and naval service all those, first, who have tuberculosis in any active form, second, those who have tuberculosis in an inactive form which has any slight likelihood of being reactivated by the exercise and exhaustion concomitant with service in active warfare and, third, those in whom there will be too large a percentage of tuberculosis develop even though perfectly normal at the time of examination.

The Government has half solved the first group, that of the active tuberculous, by decreeing that every candidate for the honor of defending his Country have an x-ray examination of the chest, but no provision has been made for x-ray survey of the men now in the services. Bringing in recruits who have been carefully selected and surveyed for tuberculosis elimination, and then mixing them with the unsurveyed group now in the Army and Navy service, is like sorting apples at great expense and upon completion of the procedure, mixing the sound apples with other apples, some of which are rotten. Persistence in such procedure will entitle our Democracy to bear, without complaint, some of the charges of futility made by Totalitarians. X-ray of *all* Service men, new and old, should eliminate most immediately infectious cases, providing x-ray of known value and not new experimental methods, are used. The only methods that have had any extensive use, and with which any considerable numbers of interpreters of x-ray films have had any experience, are the 14x17 gelatine and paper films. Both are adequate, and only they are proven adequate, for this huge and tremendously important task.

E. L. Cooper (Brit. M. J., 2: 245, Aug. 24, 1940), reporting a survey of 9000 Australian Cadets by the 35 mm. film, makes what are apparently contradictory statements. He

states, "Whenever anything abnormal is detected in the 35 mm. film, a large roentgenogram is taken next day. In 541 (or 6 per cent) of the 9000 recruits, 14x17 inch films were ordered" and again, "4830 (54 per cent) of the microroentgenograms showed evidence of hilar calcification suggestive of a healed primary tuberculous infection."

Cooper thus goes on record as regarding hilar calcification suggestive of a healed primary tuberculous infection as a normal finding. It has been shown by Ch'iu (J. A. M. A., 112: 1906, May 13, 1939), however, that even in a positive tuberculin group of children, age 7 years, the incidence of active pulmonary tuberculosis will be ten times greater than in the negative tuberculin group, within ten years or more.

Cooper, states, however, "Enthusiasm for a relatively cheap method of detection of tuberculosis must not be allowed to outstrip caution. With our present technique, micro-radiography can only be regarded as an adjunct to radiography by the well-tried methods of large x-ray films. No one should be labeled tuberculous on the unsupported evidence of a 35 mm. film." After the war is over, then, if this is so, what defense will the Veterans Bureau have against illegitimate claims for compensation, if the only x-ray record on file during or prior to service is a micro film?

The selection of candidates from the other two groups, those that have had tuberculosis and those that are likely to develop it, remains the real staggering Tuberculosis Problem in Mobilization today. Yet, curiously, we have heard very little mention of it. Our Government should approach the problem with utmost solicitude and study, because any overlooking of the help they can get in this matter means not only the loss of countless precious lives, the suffering in toto of thousands of years of invalidism, the ruin of countless families, but also a staggering loss of Government funds. Thought on the matter should weigh the following facts:

* Delivered November 21, 1940, before the Philadelphia County Medical Society, Philadelphia, Pennsylvania, under the auspices of the Committee on National Defense of the Philadelphia County Medical Society.

1. Life insurance companies have been avoiding these risks in this age group.

2. These companies have, through the years, given greatest study to the problem.

3. In this age group, the insurance companies refuse standard rate insurance to applicants with bad tuberculous family history and always couple the family history with underweight. One parental or fraternal case of pulmonary tuberculosis is not considered by them as great a risk as two or more in the family of the applicant.

4. The life insurance company, if it guesses wrong, only has to pay the death claim, some of which the insured has always paid in to the company.

5. If the United States Government guesses wrong in accepting an applicant for military or naval service and that applicant develops tuberculosis, the Government, judging by the last war procedure, must (a) hospitalize the patient, (b) pay him during disability, (c) pay his government insurance policy when he dies, (d) pay him as long as he lives if his case is apparently cured, and (e) last and worst, the Government must do all of these things for all the other soldiers and sailors that he infects with his disease before he is diagnosed and separated from them. Under war conditions, this diagnosis may be made very late, as those of us who were Medical Officers with fighting troops during the last war, can testify. Living in crowded quarters, as soldiers and sailors must do at best, and at times sleeping on the ground with several bodies under the same little shelter half, heads and all, with the consequent rebreathing of each others breath, makes one case of infectious tuberculosis a frightful menace to all about him.

What needs to be done?

Space, on the questionnaire the applicant for voluntary or drafted service fills out, should be provided for tuberculous family history. When deaths have occurred in the family of the applicant, official copies of death certificates should be supplied by the applicant. All living positive sputum cases in the family should be attested by a sworn affidavit of the Sanatorium Director where they were treated, or by the physician in charge of them. Sputum reports of an official

nature would be available in many laboratories.

It is true that this will all entail a lot of extra work, but look at the result to be expected. Of group 2, those cured of any form or stage of tuberculosis, rejection of all of these that have a bad tuberculous family history will eliminate almost all who are liable to have recurrence of activity and become infectious. It is well known, however, that if the tuberculous family history is bad, the so-called cure is very likely to be temporary even under ideal conditions, and is most likely to be so under conditions of strenuous exercise and physical exhaustion to be encountered in war service.

Of group 3, those should be excluded from service, who have been exposed to two or more immediate relatives, parental or fraternal, who have died of tuberculosis or are, or have been, positive sputum cases of the disease. One such should be sufficient for rejection if the applicant is under average weight.

These precautions will result in eliminating not only the cases with tuberculosis in an infectious phase, but most cases that can be expected to become so. Such precautions will make it safer to bring men from healthful, relatively tuberculosis free areas and mix them with men accustomed to heavier tuberculosis exposure, without the dread sequence experienced in the last war of great numbers of men developing severe types of tuberculous infection. The severity probably was due partly to their previous inexperience with the tuberculosis organism, but they were confronted with the doubly difficult feat of accomplishing immune reactions while depleted with physical, and often mental, exhaustion.

Every text book ever written on tuberculosis, dwells at length on the importance of family history in reaching an opinion regarding the likelihood of tuberculosis developing. Most finding of tuberculosis, before it became infectious, has been done through seeking contacts of known tuberculous and keeping those contacts fit through repeated follow-up and guidance to prevent the potential breakdown into active infectious disease. Every medical student has the importance of the family history of tuberculosis drilled into him most thoroughly in medical school. Why, why should that importance of the tuberculous

family history be forgotten by doctors now, who are responsible for the health, as well as the lives of our precious defenders? Of all veterans who died as a result of service in our last war and whose dependents are now receiving benefits, 31 per cent died from tuberculosis. That disease has cost the Government one billion dollars besides all those lives, since the war, and spending will go on another 40 years for the tuberculosis bill of that war 23 years ago.

Is it possible that the medical chiefs of our Army and Navy are lulled into false security because of the fact that there is little develop-

ment of active tuberculosis in the Army and Navy personnel during peace time? Why should there be? Such a large percentage of them live in healthful surroundings, in camps comparable to tuberculosis sanatoriums, with financial security, ample food, no overcrowding and certainly, very little overwork.

War time changes all that. We are getting ready for war. In these matters, the tuberculosis specialists, who are self-maintaining, who are not supported by the Charity Tuberculosis Dollar and who have nothing to sell, should be heeded.

The Therapeutic Use of Iodized Oil in Chronic Bronchitis and Bronchiectasis

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E. RAYMOND FENTON, M.D.
Washington, D.C.

Until recently the treatment of chronic bronchitis and bronchiectasis had undergone no material change and had not kept pace, in our opinion, with modern therapeutic measures in other branches of medicine. As we all know, the medical treatment has consisted of various cough medicines including iodides and creosote and different forms of medicated inhalations. Stock and autogenous vaccines have been used, and heliotherapy has been practiced to some extent. Arsphenamine given intravenously has been advocated when Vincent's organisms are present. Postural drainage has been recommended for many years. This resumé covers essentially the usual therapeutic measures employed in chronic bronchitis and bronchiectasis during the past century.

In more recent years a number of new methods of treatment have been developed. We desire to report upon our experience with one of the most generally used modern treatments, namely, the use of iodized oil, with as accurate an estimate as possible of its therapeutic value.

The French were pioneers in the use of iodized oil in the bronchial tract. Sicard and Forestier¹ in 1922 were the first to use this method. It was done for the sole purpose of

diagnosing bronchiectasis. They found in a short time, however, that some patients injected with iodized oil showed improvement in their clinical symptoms. More recently, Cole and Nalls,² Burge and Post,³ Balyeat,⁴ Weinberg,⁵ Ochsner,⁶ and others in this country have advocated the use of iodized oil in the bronchi as a therapeutic measure for chronic bronchitis and bronchiectasis.

About three years ago we decided to adopt this method of treatment. The preparation we have been using is lipiodol, a poppy seed oil containing 40 per cent iodine. The iodine is chemically combined with the oil so that no free iodine is present, but this iodine is liberated so slowly that it is nonirritating. So much weight is added to the oil by the iodine that gravity carries it to the bottom of the cavity of the bronchus, mechanically floating any pus or secretions to a higher level where it can be coughed up. We have noted by fluoroscope, especially in asthma cases, mucous plugs abruptly obstructing the flow of the oil and on later examination have found the oil in the lung, the plug apparently having been coughed up. We feel that the iodine has natural expectorant qualities in the bronchi. By absorption it gives a continuous mild tonic effect.

Complete chest, x-ray and sputum examinations are given each patient before oil is used. We also give them iodides internally for a short time to be sure they are not sensitive to iodine. Then, as an added precaution, we use an extremely small dose of oil for the first treatment, not over 1 c.c. in each side. We consider the chief indication for therapeutic use of iodized oil to be cough and expectoration in non-tuberculous patients who have not responded to the usual forms of treatment. After instillation of iodized oil, fluoroscopic examination and x-ray films may disclose what we are dealing with in the bronchial tract.

Contraindications are (1) active pulmonary tuberculosis, (2) acute infection, and (3) myocardial weakness, especially with pulmonary edema.

It is highly important to make a fluoroscopic examination before and after each injection of iodized oil in order, first, to determine the condition of the bronchial tract; second, to confirm the presence of the oil in the tubes; and, third, to determine the amount of retained oil from previous treatments. One often finds retained oil from previous treatments on one side and almost complete absence of oil on the other side. Burge⁴ has noted oil retention for from 24 hours to many months, and in one case, for two years. Moreover, in cases of bronchial asthma in which it is necessary to inject the upper lobes with oil, a fluoroscopic checkup is essential to assure accomplishment of this purpose.

We have been using 2 per cent Pontocaine as our anesthetic dropping, on the average about 1.5 c.c. on the base of the tongue and allowing it to flow into the larynx. Quite a few of our patients, veterans of several treatments, have been taking reduced doses of anesthesia. Dr. F. W. Burge⁷ has suggested instillation of the oil without anesthesia. Recently, we have treated a few cases without anesthesia with excellent results; in fact, in one asthmatic there was decidedly less coughing. We have experienced no serious reactions from this synthetic anesthesia, although a few reported "a ball in throat" and "numbness" for as long as two hours after treatment. Until these symptoms are gone we recommend that the patient take no food or liquid.

We have given iodized oil to patients who have chronic coughs of many months' or years' duration and who have not responded to any other form of treatment. This is the type of case that in the past has gone for months and years without obtaining any relief and that we considered hopelessly chronic. Many of these patients have obtained marked or complete relief of their symptoms. Success in relieving cases of chronic bronchitis, a number of which were complicated by bronchial asthma, has been obtained. Incidentally, the asthma has also been relieved. Alison,⁸ Taylor,⁹ Fink,¹⁰ and Balyeat¹¹ have reported good results in the treatment of bronchial asthma by the use of iodized oil. We have been much less successful in our cases of advanced purulent bronchiectasis, but have had some quite favorable results in the milder types of bronchiectasis. Following the repeated injections of iodized oil, we have noted the relief of cough and expectoration, an improvement in the general condition of the patient, and frequently a gain in weight. Over five hundred injections of oil to a total of 62 patients have been administered in our office.

Symptoms of iodism followed only 1 injection. This patient received later treatments without iodism. Goldstein¹² reports a death of a 47-year-old man. Twenty c.c. of the iodized oil was used for diagnosis. Death was attributed to nephritis and overwhelming toxemia. We have obtained excellent results from small doses of the oil, and our freedom from complications may be due in part to the use of these small doses.

Illustrative Cases

Case 1: Mr. J. H. W., aged 74 years, was referred to us by Dr. Carden Warner on November 15, 1937. The patient gave a history of persistent and annoying cough with expectoration for the past year. He had received treatment from several physicians and had spent the previous winter in California, but had obtained no relief. Physical examination, x-ray film and intracutaneous tuberculin test showed no evidence of pulmonary tuberculosis or other disease of the lungs. Diagnosis was made of chronic bronchitis and on November 19, 1937 iodized oil treatment was started. He received weekly treatments of

from 2 to 3 c.c. of oil for 3 weeks and then treatment was given at intervals of 2 weeks. Finally, treatment was given at monthly intervals. Eighteen treatments in all were given, but he was entirely free of symptoms in 3 months, after receiving only 10 treatments. He had had no recurrence of bronchitis 10 months after his last oil instillation. His x-ray examination after oil was injected showed no evidence of bronchiectasis.

Case 2: Mr. J. W. A., 65 years of age, was referred to us by Dr. Sidney Cousins on March 14, 1937. He gave a history of chronic cough and expectoration for the past 3 years, with attacks of asthma which had been becoming more frequent and had interfered with his work for several months. We put him on vaccines, ultra-violet light, potassium iodide and ephedrine and amytal internally. This helped him some for a few months, but he then became progressively worse. Adrenalin gave temporary relief. On January 2, 1938 we started him on iodized oil instillations of 2 to 3 c.c., first at intervals of 5 days and later of 2 weeks and finally 4 weeks. His asthma cleared up in 2 months. His bronchitis gradually improved. He received his last treatment July 10, 1938 and states he has had no return of the bronchitis or asthma during the past two years. X-ray examination after using iodized oil showed no bronchiectasis.

Case 3: Mr. E. O., aged 38 years, came to us October 7, 1938. He gave a history of severe paroxysmal cough with moderate expectoration for a period of 4 months. His cough was worse at night and he complained of wheezing and dyspnea. Physical examination, x-ray films and sputum examination were negative to tuberculosis. His symptoms were so severe that he was unable to work for several weeks. We started him on iodized oil treatments on October 16, 1938, giving him treatments of 2 to 3 c.c. at weekly intervals the first month, then at intervals of 2 weeks. His symptoms improved decidedly in 3 weeks and he was able to return to work. He has continued to improve and now has only a slight cough and expectoration a few times a day. His wheezing and dyspnea, he states, have completely disappeared. His x-ray films after injection of iodized oil showed a mild bronchiectasis on the left side.

Case 4: Miss M. M., aged 40 years, referred

to us October 8, 1937 by Dr. E. W. Titus, gave a history of cough with rather profuse expectoration for the past 3 years. She had no history of bad taste or odor to the sputum. She had rather frequent mild asthmatic attacks at night. She continued to have these symptoms in spite of vaccine treatments, potassium iodide and later creosote and sedative cough remedies. On April 26, 1938, 18 months after we first saw her, we started iodized oil instillations. The usual methods outlined in the previous case reports were used, and she began to steadily improve. She now takes treatments once in 6 weeks and claims she has had no cough, expectoration or asthma for the past 4 months. Her x-ray films after the use of oil showed a mild bronchiectasis at the base of the left lung. In view of the fact that a mild bronchiectasis was present, we feel this is a rather remarkable result in a case where symptoms had persisted for five years.

Case 5: Mrs. H. LaF., aged 26 years, came to us for examination September 10, 1937. She gave a history of cough with profuse expectoration for the past 6 years. The sputum had a bad taste and fetid odor. She had coughed blood on two occasions. Physical examination and x-ray films taken after oil injections, showed an extensive bronchiectasis at the base of the left lung. We have had no improvement whatever except a diminished odor to her expectoration. We feel that a lobectomy is the only method by which this patient may obtain relief.

Case 6: Mr. G. H., aged 41 years, consulted us on February 15, 1940. He gave a history of bronchial asthma since August, 1938. He took adrenalin hypodermically and by inhalation for relief, also treatment including skin testing, diets and rest in Pennsylvania mountains, with no relief. His grandmother had asthma. He was given saturated solution of potassium iodide and on February 23, 1940, iodized oil instillations were begun. His bronchogram showed some slight tubular dilatation in the right lower lobe. He has taken 11 treatments, including two to the right upper lobe, with almost complete relief of symptoms.

On analyzing the 62 cases treated with iodized oil, we classified 29 as having no anatomic defects as determined by broncho-

grams, although they had cough and expectoration not relieved by the usual means. We labeled these simple bronchitis without asthma. The results are 9 relieved, 8 much improved, 9 improved, and 3 unimproved.

There were 12 cases with typical bronchial asthma which, after bronchograms, were diagnosed as bronchitis. Of these, 3 were completely relieved of their bronchitis and asthma, 5 were much improved, and 4 were improved.

Four more cases with bronchial asthma showed a mild bronchiectasis in the bronchogram. Following treatment, 1 was relieved, 2 were improved, and 1 was unimproved.

There were 9 cases that showed definite, though not marked, dilatation deformities of the bronchi following iodized oil. These we termed mild bronchiectasis. Of this number, 2 were relieved of all symptoms, 6 were much improved, and 1 was improved. One of the cases classified as "much improved" had to have his bronchiectatic cavity kept fairly well filled with oil to control his symptoms.

Six of our cases showed marked anatomic bronchial defects. We classified these as advanced bronchiectasis. In these, the clinical improvement was very slight. The expectoration was made easier and at times would be reduced in amount. The end results were considered poor and we classified them all as unimproved.

We treated two cases which we termed a

spastic type of bronchitis without typical asthma. They did not return for a sufficient number of treatments. Both of these were unimproved.

Summary

We have treated a total of 62 cases with iodized oil. Of this number 52 patients, or 83.87 per cent, obtained either complete or partial relief of their symptoms. Ten patients, or 16.13 per cent, obtained no definite relief.

We feel after three years' experience that the therapeutic use of small doses of iodized oil in the bronchial tract is a safe procedure and a distinct advance in the treatment of chronic bronchial conditions. In our opinion this treatment should be used more generally in the future than it has been in the past.

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TUBERCULOSIS COMMITTEES IN MISSOURI

Dr. E. E. Glenn, Springfield, Missouri; A.C.C.P.) Chairman of the Tuberculosis Committee of the Missouri State Medical Society, reports that the following Tuberculosis Committees have been established in the County Medical Societies in Missouri:

- Dr. T. F. Miller, Lamar, *Chairman*;
Barton County Medical Society.
- Dr. T. S. Reser, Warsaw, *Chairman*;
Benton County Medical Society.
- Dr. H. E. Peterson, St. Joseph, *Chairman*;
Buchanan County Medical Society.
- Dr. J. L. Mudd, St. Louis, *Chairman*;
St. Louis Medical Society.
- Dr. Lawrence E. Wood, Kansas City, *Chairman*;
Jackson County Medical Society.

- Dr. R. H. Runde, Mount Vernon, *Chairman*;
Lawrence-Stone County Medical Society.
- Dr. E. E. Glenn, Springfield, *Chairman*;
Greene County Medical Society.
- Dr. George W. Newman, Casseville, *Chairman*;
Barry County Medical Society.
- Dr. A. H. Spelman, Smithville, *Chairman*;
Clay County Medical Society.
- Dr. I. D. Kimes, Cameron, *Chairman*;
Clinton County Medical Society.
- Dr. J. B. Luten, Caruthersville, *Chairman*;
Pemiscot County Medical Society.
- Dr. J. P. Burke, Jr., California, *Chairman*;
Moniteau County Medical Society.

Dr. H. I. Spector, St. Louis, is the Governor of the College for the State of Missouri and he has been one of the leaders in promoting the organization of a Tuberculosis Committee in the State Medical Society.

REPORT

Committee for the Advancement of Tuberculosis Organization in Medicine

BENJAMIN GOLDBERG, M.D., F.A.C.P., F.A.C.C.P.*
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One of the primary objectives of the American College of Chest Physicians has been that this Organization, in its attempt to improve the status of tuberculosis work in this and other countries, would always function in close coordination with the tenets of organized medicine. To make doubly certain of such a tieup, this committee, The Committee for the Advancement of Tuberculosis Organization in Medicine, first came into being three years ago and since then has devoted its activities entirely to that thought.

It was determined that first there should be a Committee for Tuberculosis appointed in every State Medical Society, which Committee stimulated in its appointment through the American College of Chest Physicians, would have, if possible, one or more fellows of the College as members and would function to achieve a program known as the Pennsylvania Plan. The important provisions in it have been presented to members of this society at different meetings, and have in the progress of the development of the College been recorded in its official journal.

We feel it would be wise to again mention the salient features of this plan, which are as follows:

I. Case Finding.

- a. Education of the Public.
- b. Education of the Medical Profession.
- c. Education of the State Legislators.
- d. Method and Proper Cost of Case Finding.

II. Case Treatment.

III. Rehabilitation.

We should also give praise to the fine work of Dr. Ralph Matson, as Chairman of this Committee, over a period of two years, in furthering the development of this Committee, and also in the achievements which were accomplished under his chairmanship during

that time.

During the current year, the new committee appointed to continue Dr. Matson's work has carried on in the following way: The country was divided into small groups of states with committee members responsible for the organization of each group. The Chairman sent a letter to the governor for the College in every state and gave detailed information as to the program of work of the Committee. A plea for cooperation was also made so that in this year we might possibly achieve the complete organization of every state in the union. Along with this, a definite effort was made to further the organization of committees on tuberculosis in county medical societies. At the present writing 37 states including Puerto Rico and the Phillippine Islands have tuberculosis committees appointed and organized in their State Medical Societies. Sixteen of these states report more than 254 county medical societies as having appointed tuberculosis committees in these societies. The snowball rolling downhill is becoming an avalanche and perhaps in another year of intensive work the completion of the completed organization for states and counties will have been entirely achieved.

Coincidentally with the development of the committees, there is a natural increase in the dissemination of tuberculosis knowledge and tuberculosis activity, which in no small way has been a contributing factor to the continuance of the decrease in tuberculosis morbidity and mortality in this country. The private general practitioner of medicine is the first line of defense in public health work. The patient in a majority of instances gives his confidence to the practitioner, and he should be the one who should receive the education essential to discover the pathology and properly direct the patient into those channels where adequate therapy will be given. This is one of the most motivating factors in the development of the system of organization promulgated by this committee.

* Chairman of the Committee. Other Committee members: Karl Schaffle, M.D., Vice-Chairman; M. Jay Flipse, M.D.; Harry Golembe, M.D.; Edward A. Greco, M.D.; Louis Mark, M.D.; John Roberts Phillips, M.D.; Benjamin Shepard, M.D.; and Wm. C. Voorsanger, M.D.

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University of Oregon Medical School and the
Pacific Northwest Section of the
American College of Chest Physicians
Cooperating

DECEMBER 13 and 14, 1940

Auditorium, Medical School
Portland, Oregon

PROGRAM

REGISTRATION: 8:00 A. M. at the Auditorium, University of Oregon Medical School.

December 13, 1940

MORNING SESSION—*Dr. Grover C. Bellinger, Salem, Oregon, Chairman

A.M.		
8:45- 9:00	Address of Welcome	Dr. R. B. Dillehunt, Dean
		<i>Presentation:</i>
9:00- 9:15	Heart Diseases Peculiar to Chest Conditions, I	Dr. Ernest L. Boylen Portland, Oregon
9:20- 9:35	Body Section Radiography	Dr. William Y. Burton Portland, Oregon
9:40- 9:55	Intrapleural Pneumonolysis	*Dr. William S. Conklin Portland, Oregon
10:00-10:15	Occupational Therapy	*Dr. John W. Unis Seattle, Wash.
10:20-10:35	Muscle Flaps in the Closure of Residual Empyema Cavities or Bronchial Fistulae	*Dr. Ralph C. Matson Portland, Oregon
10:40-11:00	Anaesthesia in Thoracic Surgery	Dr. John H. Hutton Portland, Oregon
11:10-11:40	Chemotherapy in Subacute Bacterial Endocarditis	Dr. Edwin E. Osgood Portland, Oregon
		<i>Discussion:</i>
		Dr. Howard P. Lewis Portland, Oregon
		Dr. Herman F. Inderlied Portland, Oregon
		*Dr. A. T. King Salem, Oregon
		*Dr. Howard L. Hull Yakima, Wash.
		*Dr. Oscar S. Proctor Seattle, Wash.
		Dr. Joseph M. Roberts Portland, Oregon
		Dr. Laurence Selling Portland, Oregon

LUNCHEON SESSION—*Dr. James M. Odell, The Dalles, Oregon, Presiding

12:00 noon Round Table Discussion

AFTERNOON SESSION—*Dr. John E. Nelson, Seattle, Washington, Chairman

P.M.		
2:00- 2:15	Bronchoscopy in Diseases of the Lungs	Dr. Ralph A. Fenton Portland, Oregon
2:20- 2:35	Allergy and Tuberculosis	*Dr. P. Schoenwald Seattle, Wash.
2:40- 2:55	Chest Pain	*Dr. Marr Bisailon Portland, Oregon
3:00- 3:15	Nutrition in Tuberculosis	*Dr. Grover C. Bellinger Salem, Oregon
3:20- 3:35	The Extrapleural Pack	*Dr. James S. Conant Portland, Oregon
3:40- 4:00	Tuberculosis Empyema: A Plea for More Uniform Management	*Dr. F. A. Slyfield Seattle, Wash.
4:10- 4:40	The Reflex and Chemical Control of Respiration	Dr. Hance F. Haney Portland, Oregon
		*Dr. James M. Odell The Dalles, Oregon
		Dr. Robert L. Benson Portland, Oregon
		Dr. William K. Livingston Portland, Oregon
		*Dr. M. H. Axline Seattle, Wash.
		*Dr. Ralph C. Matson Portland, Oregon
		*Dr. Howard L. Hull Yakima, Wash.
		Dr. William B. Youmans Portland, Oregon

EVENING SESSION—*Dr. Ralph C. Matson, Presiding

6:00 Dinner at the University Club
The Present Status of Surgical Treatment in Cancer of the Esophagus

Dr. Thomas M. Joyce, Professor of Surgery,
University of Oregon Medical School

December 14, 1940

MORNING SESSION—*Dr. Orval S. Swindell, Boise, Idaho, Chairman

A.M.		Presentation:	Discussion:
9:00- 9:15	Heart Diseases Peculiar to Chest Conditions, II	Dr. Homer P. Rush Portland, Oregon	Dr. Frank R. Mount Portland, Oregon
9:20- 9:35	The Diagnosis of Pulmonary Tuberculosis	Dr. Howard P. Lewis Portland, Oregon	*Dr. Leslie P. Anderson Elma, Wash.
9:40- 9:55	Pneumoperitoneum with Phrenic Paralysis	*Dr. Leon G. Woodford Everett, Wash.	*Dr. James M. Odell The Dalles, Oregon
10:00-10:15	Roentgenography in Gastro-intestinal Tuberculosis	Dr. Dorwin L. Palmer Portland, Oregon	*Dr. Grover C. Bellinger Salem, Oregon
10:20-10:35	Clinical Applications of Bronchoscopy	Dr. Paul Bailey Portland, Oregon	Dr. F. A. Brown Portland, Oregon
10:40-11:00	The Pathology of Cancer of the Lung	Dr. Frank R. Menne Portland, Oregon	*Dr. Marr Bisailon Portland, Oregon
11:10-11:40	Electroencephalography and its Relationship to Nervous and Mental Disease	Dr. G. B. Haugen Portland, Oregon	Dr. H. H. Dixon Portland, Oregon

LUNCHEON SESSION—*Dr. Byron F. Francis, Seattle, Washington, Presiding

12:00 noon Round Table Discussion

AFTERNOON SESSION—*Dr. Frank I. Terrill, Dear Lodge, Montana, Chairman

P.M.			
2:00- 2:15	Artificial Pneumothorax	*Dr. Leslie P. Anderson Elma, Wash.	*Dr. Byron F. Francis Seattle, Wash.
2:20- 2:35	Transpleural Aspiration of Tuberculous Cavities	*Dr. James S. Conant Portland, Oregon	*Dr. M. H. Axline Seattle, Wash.
2:40- 2:55	Appraisal of the Tuberculin Test	*Dr. John E. Nelson Seattle, Wash.	Dr. K. M. Soderstrom Seattle, Wash.
3:00- 3:15	Sodium Tetradecyl Sulfate in the Treatment of Tuberculous Empyema	Dr. John E. Tuhy Portland, Oregon	*Dr. Ralph C. Matson Portland, Oregon
3:20- 3:35	Brain Abscess in Acute Pulmonary Infection	Dr. John Raaf Portland, Oregon	Dr. Laurence Selling Portland, Oregon
3:40-4:00	Extrapleural Pneumothorax	*Dr. Oscar S. Proctor Seattle, Wash.	Dr. K. M. Soderstrom Seattle, Wash.
4:10- 4:40	Chemotherapy in Pneumonia	Dr. Edwin E. Osgood Portland, Oregon	Dr. Roger H. Keane Portland, Oregon

* Fellows of the American College of Chest Physicians.

Arrangement Committee

DR. RALPH C. MATSON, *Chairman*

Associate Clinical Professor, University of Oregon Medical School, Past President of American College of Chest Physicians.

DR. JAMES S. CONANT

Fellow in Thoracic Surgery, University State Tuberculosis Hospital, Portland, Oregon; Fellow of the American College of Chest Physicians.

RALPH COUCH

Administrator, Hospitals and Clinics, University of Oregon Medical School.

NOTICE TO MEMBERS

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PAUL H. HOLINGER, M.D., F.A.C.C.P.
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Scientific Program

of the

New York State Chapter of the American College of Chest Physicians

January 17, 1941

Hotel Biltmore, New York City

MORNING SESSION

Chairman—Dr. Edgar Mayer, New York City

9:15—Registration of members and guests

9:30—"Bronchoscopy in Diseases of the Chest"

Dr. Chevalier L. Jackson, Professor of Broncho-Esophagology, Temple University School of Medicine, Philadelphia, Pa.

10:15—"Surgery of Carcinoma of the Lung"

Dr. W. Emory Burnett, Professor of Clinical Surgery, Temple University Medical School, Philadelphia, Pa. Associate Surgeon and Thoracic Consultant, Philadelphia General Hospital.

Clinical Discussion of Carcinoma of the Lung by

Dr. George G. Ornstein, Associate Professor of Clinical Medicine, New York Post-Graduate Medical School and Hospital, New York City. Director of Medicine, Seaview Hospital and Director of Tuberculosis, Metropolitan Hospital, New York City.

Surgical Discussion of Carcinoma of the Lung by

Dr. Samuel Alcott Thompson, Associate Professor of Surgery, New York Medical College and Director Department of Thoracic Surgery, Metropolitan Hospital, New York City.

Pathological Discussion of Carcinoma of the Lung by

Dr. Frank W. Konzelmann, Professor of Clinical Pathology, Temple University School of Medicine, Philadelphia, Pa.

11:45—"Industrial Pulmonary Diseases"

Dr. Leonard Greenburg, Executive Director Division of Industrial Hygiene, Department of Labor, State of New York.

12:30—LUNCH

AFTERNOON SESSION

Chairman—Nelson W. Strohm, Buffalo, N. Y.

2:00—"Tuberculosis in the Army Under the Present Epidemiologic Conditions"

Dr. Edgar Mayer, Associate Professor of Clinical Medicine, Cornell Medical School, New York City.

Discussion by Dr. Israel Rappaport, New York City

2:45—"Postoperative Atelectasis-Diagnosis-Prevention and Treatment"

Dr. Arthur Q. Penta, Lecturer on the Mycotic and Fuso-Spirochetal Infections of the Lungs, Temple University Medical School, Philadelphia, Pa. Director Department of Bronchoscopy, Schenectady City Hospital, Schenectady, N. Y.

3:15—"Artificial Pneumothorax in the Treatment of Pulmonary Tuberculosis"

(Sound Motion Picture)

Dr. James S. Edlin, Adjunct Clinical Professor of Medicine, Polyclinic Medical School. Director Department Thoracic Diseases, Polyclinic Hospital, New York City.

Dr. Sydney Bassin, Assistant Attending, Municipal Sanatorium, Otisville, N. Y.

Dr. Walter Lichtenberg, Assistant Attending, City Hospital, New York City.

4:15—Business Meeting

OFFICERS

New York State Chapter
of the

American College of Chest Physicians

President DR. EDGAR MAYER
Vice-President DR. NELSON W. STROHM
Secretary DR. ARTHUR Q. PENTA

Governor of the College for the State of
New York DR. GEORGE ORNSTEIN
Regent of the College for the State of
New York DR. EDWARD P. EGLEE

READER NOTICE

Under the rules laid down by the American Academy of Pediatrics, their new educational-to-the-public film "When Bobby Goes to School" may be exhibited to the public by any licensed physician in the United States.

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A. D. LONG, M.D.
MEDICAL DIRECTOR

Organization News

ILLINOIS STATE CHAPTER MEETS

A joint meeting of the Illinois State Chapter of the American College of Chest Physicians and the Chicago Tuberculosis Society was held at the Bismarck Hotel, Chicago, Illinois, on November 18, 1940.

After the dinner, Dr. John Alexander, Ann Arbor, Michigan, spoke on *The Management of Bronchiectasis*. His talk was enthusiastically received and was discussed by several men including Professor Carlson of the University of Chicago and Dr. Paul H. Holinger of Chicago.

Preceding the dinner, Dr. Robert K. Campbell, President of the Illinois State Chapter of the College, presided over a business meeting of the Chapter. Out of state guests were Dr. John H. Peck, Oakdale, Iowa, President of the American College of Chest Physicians; Dr. Jas. H. Stygall, Indianapolis, Indiana, Governor of the College for Indiana; and Dr. H. I. Spector, St. Louis, Missouri, Governor of the College for Missouri. The State Charter issued by the Board of Regents of the College was formally presented. Illinois has the distinction of holding State Charter No. 1 for organizing the first State Chapter of the College.

Dr. Benjamin Goldberg, Chicago, Illinois, President Elect of the American College of Chest Physicians, reported on the progress made for the Scientific Program being arranged for the annual meeting of the College to be held at Cleveland, Ohio in 1941.

Following this, a round table discussion was held regarding the plans for the coming year for the Illinois State Chapter. It was decided to hold the next meeting of the Chapter in conjunction with the meeting of the Illinois State Medical Society and a program on chest diseases will be presented at that time.

A resolution was presented and passed inviting the Iowa Fellows of the College to participate in all future meetings of the Illinois State Chapter.

PRESIDENT ELECT VISITS IOWA

Dr. Benjamin Goldberg, Chicago, Illinois, President Elect of the American College of Chest Physicians; addressed the medical students at the University of Iowa Medical School, Iowa City, on the morning of November 6th, and the Iowa Sanatorium Association and the Johnson County Medical Society in the afternoon and evening of the same day. He spoke on *Pathogenesis of Tuberculosis*, *Medical Teaching in Tuberculosis* and *The Wandering Tubercle and its Reactions*.

DR. CHAS. J. KOERTH DIRECTS SUCCESSFUL BOND ISSUE

Dr. Chas. J. Koerth, San Antonio, Texas (A.C.C.P.) Medical Superintendent of the Woodmen of the World War Memorial Hospital received the praise of the San Antonio press and public for his able leadership in conducting a successful campaign for a bond issue to build a new tuberculosis unit at the County Sanatorium at Southton, Texas; and for the establishment of a pneumothorax and diagnostic clinic at the Robert B. Green Memorial Hospital, San Antonio.

The \$285,000.00 bond issue carried at the polls by a plurality of a little over 500 votes, according to the "San Antonio Light." This small plurality shows the close and keen fight that was waged for the passage of the bond issue, and Dr. Koerth has received the major portion of the credit for his determination to win the issue in the face of a strong opposition.

Contracts for construction of the new units will be let just as soon as the plans can be approved and our congratulations go to the citizens of San Antonio and to Dr. Koerth.

ELECTIONS

Dr. Paul A. Turner (Governor A. C. C. P.) Louisville, Kentucky, is the retiring president of the Southern Tuberculosis Conference and H. Frank Carmen (Regent A. C. C. P.) of Dallas, Texas, the newly elected president of the Conference. Dr. John H. Peck, Oakdale, Iowa, President of the American College of Chest Physicians, attended the meeting.

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NEW JERSEY STATE CHAPTER MEETS

Minutes of the meeting held Nov. 7th, 1940, Thursday, at the Rogers Smith Hotel, New Brunswick, N. J.

Luncheon was served at One O'Clock.

The meeting was called to order by the vice-president, Dr. Joseph Morrow, in the absence of the president, Dr. M. H. Collier. Dr. Collier sent in his regrets being unable to attend due to unavoidable circumstances.

Topics for Discussion:

1. Participation in the program at the annual meeting of the State Medical Society.

The group present accepted Dr. Morrow's offer to represent the New Jersey Chapter of the College with an exhibit at the next annual meeting of the New Jersey State Medical Society. All members are requested to send suitable material to Dr. Morrow for such an exhibit.

2. Education of the General Practitioner.

There was unanimous agreement that the Chapter sponsors at least one chest paper at each County Medical Society, annually, this to be presented by some prominent authority. Efforts are to be made for educating the negro physician in chest work.

3. It was suggested that a copy of the pneumothorax directory, published by the College, be mailed to the office of each County Medical Society with the request that the names of those residing in the County be published in the monthly Bulletin.

4. By-Laws.

It was voted that the president appoint a committee to prepare a Constitution and By-Laws.

5. Increase in Membership.

The consensus of opinion was that this can best be accomplished by personal interview and by maintenance of high standards.

6. Dues.

Nominal annual dues of One dollar per member was voted to cover expenditures such as postage and printing, etc. All those present paid their dues.

There being no further business, the meeting adjourned. It was agreed to meet again December 4th, 1940, at the Robert Treat Hotel in Newark, at 11 a. m.

*Charles I. Silk, M.D., F.A.C.C.P.,
Secretary*

Perth Amboy, N. J.

RHODE ISLAND FELLOWS OF
COLLEGE ACTIVE

On October 5, 1940, The Providence Medical Association had a symposium on Tuberculosis. Among the papers presented, Dr. U. E. Zambarano spoke on "Tuberculosis From the Sanatorium Point of View."

On October 8, 1940, at the Staff meeting of St. Joseph's Hospital in Providence, Rhode Island, the following papers were presented.

Early Diagnosis of Tuberculosis

Joseph Corsello, M.D., F.A.C.C.P.,
Wallum Lake, Rhode Island.

Modern Sanatorium Treatment

U. E. Zambarano, M.D., F.A.C.C.P.,
Wallum Lake, Rhode Island.

Surgical Treatment

Richard Overholt, M.D., F.A.C.C.P.,
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